Office of the Inspector General for Mental Health, Mental Retardation, and Substance Abuse Services

Virginia Center for Behavioral Rehabilitation Petersburg, Virginia Inspection

James W. Stewart, III / Inspector General

OIG Report #144-07
Issued February 6, 2008

The Office of the Inspector General conducted unannounced inspections of the Virginia Center for Behavioral Rehabilitation (VCBR) on June 27, September 4, and November 7, 2007. The purpose of these inspections was to provide an evaluative review of the active treatment program, assess census and staffing levels, and assess progress toward previously noted findings and recommendations. During this inspection the following activities took place:

- Interviews with 20 staff, including residential, security, clinical, and nursing personnel
- Interview with the executive team
- Interviews with 6 residents
- Inspection of 16 clinical records
- Observation of program areas in the facility

The following excerpts from the Virginia Code describe the purpose of VCBR and the conditions upon which an individual who has been committed to the facility may be conditionally released:

> VA Code §37.2-909 Placement of committed persons (A) - "Any person committed pursuant to this chapter shall be placed in custody of the Department (DMHMRSAS) for control, care, and treatment until such time as the person's mental abnormality or personality disorder has so changed that the person will not present an undue risk to public safety. The Department shall provide such control, care, and treatment at a secure facility operated by it or may contract with private or public entities, in or outside of the Commonwealth, or with other states to provide comparable control, care, or treatment. At all times persons committed for control, care and treatment, by the Department pursuant to this chapter shall be kept in a secure facility."

VA Code §37.2-912 Conditional release; criteria; conditions; reports (A) - "At any time the court considers the respondent's need for secure inpatient treatment pursuant to this chapter, it shall place the respondent on conditional release if it finds that (i) he does not need secure inpatient treatment but needs outpatient treatment or monitoring to prevent his condition from deteriorating to a degree that he would need secure inpatient treatment; (ii) appropriate outpatient supervision and treatment are reasonably available; (iii) there is significant reason to believe that the respondent, if conditionally released, would comply with the conditions specified; and (iv) conditional release will not present an undue risk to public safety."

VCBR became operational in 2004 at a temporary location in Petersburg and remains the only maximum security residential treatment program for civilly-committed sex offenders operated by the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS). Work is progressing on schedule for a move of the entire program to a new permanent facility in Nottoway County in February 2008.

The census of the facility is growing rapidly. At the time of the OIG's last visit to the facility, May 16, 2006, the census was 28, having doubled from the year before. At the end of the recent series of OIG visits on November 7, 2007, the census was 60. Since the facility opened in 2004, there have been a small number of discharges, all as a result of appeals and judicial decisions in the legal process. There have been no conditional releases to the community.

Background and Developments in FY2007

As reported by the facility leadership, the structure and organization of treatment programming was revised in FY2007 to reflect the diversity of populations served and to better match treatment approaches and objectives to both the needs and abilities of the persons served and their stages of treatment.

- The ultimate goal of treatment for all VCBR residents as documented in "Goals and Expectations for Treatment Phases at VCBR" (a written description of the new treatment plan) is stated as "the development of a realistic risk management plan for conditional release." Treatment is designed to "help residents move through the various phases of treatment toward conditional release to the community."
- Residents are assigned to three general tracks based on needs, abilities, and behavior of the residents. This program specialization is intended to make treatment more specific and targeted to the different needs and levels of the residents, as well as to reduce negative effects of mixing different populations and needs during treatment. The treatment tracks are as follows:
    - Sex Offender Program Track
        - Residents show good behavior.
        - Residents are cooperative with rules and staff.
        - Treatment is focused on development of a relapse prevention plan.

- Behavioral Management Program Track
  - Residents have difficulty managing their behavior and complying with rules.
  - Treatment is focused on self regulation, restructuring of criminogenic thinking, and learning prosocial behavior.
- Understanding Treatment Track
  - Residents have intellectual, medical, psychiatric, or other functional limitations that hinder their ability to benefit from treatment at the same pace as other residents.
  - Treatment goals are identical to the other two tracks, but treatment is pitched and paced at levels appropriate to the group member's needs and comprehension.

Within each treatment track, detailed phases of treatment are described. These are somewhat different for each treatment track, but follow the same pattern and objectives of advancement.

Formatted: Bullets and Numbering

- Phase I. Understanding of their own treatment needs, taking responsibility for their offenses, acknowledging their thinking errors, learning communication, problem solving skills, and self regulation skills.
- Phase II. Self awareness, understanding pathways to offending, understanding the impact of their criminal behavior on others, identification of personal risk factors.
- Phase III. Risk management: management of deviant arousal, relapse prevention plans, reducing risk.
- Phase IV. Integration. Integration of what has been learned in preparation for possible conditional release into the community.

The overall design and content of the intended treatment program at VCBR is consistent with current literature on treatment of sexual offenders and is similar to programs in other states identified by VCBR leadership as model programs.

- The use of polygraph testing on a non-mandatory basis has been implemented. Facility leadership expects this will "open up" treatment by assessment and confrontation of the veracity of residents' statements about their offenses and progress in treatment.
- The facility has developed a staff role of "Residential Coordinator" to attend to residents' non-clinical daily needs. These staff help with such functions and concerns as getting clothing and personal items, coordinating contact with families, assisting with personal needs, mail, etc. Executive team and other staff who were interviewed said that this new role reduces pressure on security staff and helps facilitate meeting residents' daily living needs.
- Program leaders stated that growth of the census, severe staff turnover in clinical positions, and very limited programming space have hindered the implementation of this new approach to treatment.
- Active planning is taking place for the move of the facility to Nottoway County. Construction of the new facility is scheduled to be completed and a transfer is planned for February 2008.

Section I – New Findings

A. Active Treatment Findings

Finding A.1: The amount of active treatment that is occurring is very limited, with levels of delivered treatment in 2007 falling 57% below those of 2006. In both years levels of treatment were below the stated expectations of facility leadership.

- All residents said that the number of treatment groups offered has dropped dramatically.
- All residents complained of boredom and lack of access to recreational activities, as well as treatment.
- Staff reported very low levels of treatment activity, though many staff were too new to be able to compare current to former levels of activity.
    - Nearly all staff reported that residents' work with their peers in groups is the most beneficial aspect of treatment at VCBR, but many noted there is not enough of it.
    - Resident boredom and acting out were reported by staff to result from limited treatment and recreational opportunities.
- Facility leadership was asked what the intended levels of active treatment are for residents per week. The average of their answers was 13.3 hours per week/per resident, with a range from 12 to 15 hours per resident/per week.
- Facility leadership was asked what the actual (delivered) levels of active treatment have been for the last six months. The average of their answers was 6.2 hours per week/per resident, with a range from 4.5 to 8 hours per week/per resident.
- OIG staff found that the level of active programming has declined significantly from activity levels noted in the 2006 OIG inspection. A review of 16 residents' records compared active treatment time in June, July, and August of 2007, to the same data for the same period in 2006 and showed the following:
    - Average total treatment time (time in groups) for the sample of residents in 2006 was 70.2 hours for the quarter, or an average of 5.8 hours per week/per resident.
    - Average total treatment time for the same residents in 2007 was 30.5 hours for the quarter, or an average of 2.5 hours per week/per resident.
        - All residents experienced a drop in active treatment levels (2 residents in the sample were not in the facility in 2006; averages were adjusted accordingly).
        - Overall treatment levels for the sample declined by 57% from 2006 to 2007.
        - Levels of treatment in 2006 and 2007 were below both what leadership said was optimal and what they estimated had been provided.

- Records showed goals and plans that are very similar among all the residents, a pattern that is comparable to other programs that serve a diagnostically homogeneous population and rely on group treatment techniques (e.g., substance abuse residential treatment).
    - When OIG staff interviewed the principal therapists responsible for the sample residents about the treatment needs, goals, and progress of each of the 16 residents in the sample, all staff replied with detailed, individualized, knowledgeable, and clinically perceptive information about the residents on their caseload.
    - When OIG staff interviewed nursing and security staff and asked them about specific residents' goals, plans, or progress, none of them professed to know anything about specific residents' treatment.
- Leadership staff were asked whether individual treatment is provided in addition to group treatment. They said that individual treatment is not indicated for this population and it is provided only by exception. Review of records showed only one instance of individual treatment for one resident.
- Residents, staff, and leadership identified staff shortages caused by frequent turnover and vacancies as the main reason for low levels of active treatment.
- Resident refusal to participate was also cited as a factor that reduces active treatment.
- Leadership noted that the program design calls for extensive availability of recreational and educational activities as well as the treatment groups discussed above. Recreational and educational activities have been virtually non-existent due to VCBR's inability to hire and retain teachers and recreational therapists, according to facility leadership. Limited space and equipment are also described as factors limiting recreational opportunities.

Finding A.2: There is not a shared vision among facility leadership, staff, and residents for the expected outcomes of services provided by the facility.

Facility Mission and Goals Statements

- The facility's mission statement refers to resident progress with a goal of providing an opportunity for "positive change." Other goals relate to secure custody, safe environment for residents and staff, and optimal use of resources. The mission statement does not refer to residents returning to the community.
- The mission statement stands in contrast to the new description of treatment tracks and phases (*Goals and Expectations for Treatment Phases at VCBR,* published by VCBR, 2007), which says that "the ultimate goal of treatment for all VCBR residents is the development of a realistic risk management plan for conditional release."

Executive Team Position

- In interviews with OIG staff the executive team described the facility's treatment goals of educating each resident about his offense and risk factors, helping each resident accept his responsibility for acknowledging harm and learning empathy for victims, and learning problem solving and relapse prevention skills. However,

they did not explicitly identify release of residents to the community as a goal for VCBR today. The facility director stated that he believes there is a "disconnect" between the very real possibility of eventual risk reduction and release of clients and the expectations of prosecutors, judges, the General Assembly, and the community-at-large that society will be protected from the residents permanently.

- The facility director expressed the opinion that the mission statement, now four years old, needs to be revised and made more "patient oriented."
- Other comments included "we prepare them, the judge decides," "there are 3-5 residents with one foot out the door (toward conditional release) now," and "we will support conditional release with substantial monitoring."

Program Supervisor Position

- Clinical supervisors said that conditional release should be the goal of treatment for all residents, noting that is what the law provides. "That is our goal for everyone – there is no one we are writing off."
- Clinical supervisors identified one resident as being "close" to readiness for conditional release and two who "could go either way."
- Clinical supervisors reported that a "risk management workbook" has been created for higher functioning residents to assess their own readiness for conditional release.

Direct Service Staff Position

- All staff were asked " under what conditions, if any, can you envision a return to community living for the majority of the residents here?"
    - 75% of the staff gave negative to very negative assessments of the possibility of any residents ever achieving discharge.
        - Many of the comments made by staff were flatly negative, denying any possibility of eventual successful treatment.
        - Four staff said the current lack of active treatment makes progress toward leaving difficult. Two mentioned that the lack of clear program expectations or timetables by which the residents can measure their progress reduces their motivation and hope as to the value of participating in treatment.
        - One clinical staff member reported hearing from residents repeatedly that treatment plans do not include preparation for eventual release. This person checked a large number of clinical records to find out if this is true and could not find any plans that had specific goals for release. (OIG review of records confirmed this, see below.)
    - 25% of the staff replied positively.
        - One staff member said that "60% could reach discharge readiness, but the clinical leadership is too pessimistic and suspicious and says I am naïve for thinking so."

Resident Position

- All residents were asked what is their long term goal for treatment at VCBR. Each responded that they hoped to return to their home communities.
- Some noted that they have not seen anyone achieve conditional release, and it seemed to them that their only practical way to leave the facility is through legal appeals.
- A majority of the residents expressed skepticism that the facility shares their goals of ultimate return to the community and doubts that their progress in treatment will result in release.

Other Issues

- Staff, clinical leadership, and the executive team noted that different kinds of treatment modalities that are not now available to residents – work training and experience in the community, graduated risk exposure and other community-based treatment experiences - will be need to be provided if discharge is to be a realistic goal of treatment.
- A review of the clinical records of 16 persons revealed goals which deal with a wide variety of learning and treatment topics for making progress in learning about and dealing with their conditions, but no goals specific to active planning for conditional release were evident for any resident. The records that were reviewed included the residents that staff identified as being closest to readiness for conditional release.

Finding A.3: The external, formal programmatic oversight of the facility is extremely limited and is significantly less than that provided for all other facilities operated or licensed by the DMHMRSAS.

- The facility is not subject to DMHMRSAS licensure, which does apply to community programs and private hospitals, and to child and adolescent programs at CCCA and SWVMHI.
- The facility is not subject to oversight (explicit regulations and inspections) from Medicaid, as are other DMHMRSAS facilities, or Medicare, which provides standards and inspects nursing and medical programs at certain facilities.
- The facility is not accredited by any independent accreditation entity (e.g., Joint Commission on Accreditation of Hospitals – JCAOH), as are other DMHMRSAS facilities. In interviews with OIG staff on November 7, facility leadership indicated that they are considering and making initial preparations to seek JCAOH accreditation as a behavioral treatment facility.
- The security elements of the facility are not subject to any standards or external oversight, such as is provided for Department of Corrections facilities or to local jails.
- DMHMRSAS Human Rights policies apply to the facility, with exceptions as approved by the Commissioner and the State Human Rights Committee, including a different method of handling resident complaints.

- The facility receives fiscal oversight from DMHMRSAS and is expected to comply with requirements for reporting critical incidents and other DMHMRSAS directives.
- The director reports to the Assistant Commissioner for Facility Operations and meets periodically with him and the other state facility directors.
- There is no oversight of VCBR by the DMHMRSAS Office of Violent Sexual Predator Services (OSVPS).
- VCBR has recently removed itself from participation in the state facility pharmacy system for what its leadership states are financial, space, and staffing reasons, in anticipation of the facility's move to Nottaway and eventual growth to perhaps as many as 300 residents. The facility contracts with a private pharmacy service. This new arrangement occurs just as DMHMRSAS, with the support of the Commissioner, Medical Director, and Director of Clinical Pharmacy Services, is attempting to improve and standardize pharmacy procedures at all the facilities and increase oversight and quality assurance of these services. The Director of Clinical Pharmacy Services was not aware of this change until after it had occurred. Only one other facility (NVTC) does not participate in the DMHMRSAS pharmacy service.
- While VCBR staff exchanges information with other persons and programs in DMHMRSAS, the Virginia Department of Corrections, and programs across the nation that serve this population, these contacts do not constitute oversight.
- No office of DMHMRSAS provides regular, formal review of program practices, or effectiveness, nor is there any routine, on-site supervision of program operations.
- No formal standards for treatment programs for sexually violent predators exist at the state or national level.
- The facility is inspected annually by the Office of the Inspector General, which also receives and investigates complaints by staff and residents.

Finding A.4: The role of medical and nursing services at VCBR is not clearly defined and these services are not integrated with clinical treatment. Relations between nursing services and administration are strained, and significant differences exist between them concerning the role of nursing services at the facility.

Nursing Staff Position

Interviews took place with all 5 current nursing staff, and medical records (8 of the 16 records in the sample) were reviewed to assess levels of medical care.

- All nursing staff reported they feel undervalued and underutilized in the treatment programs at VCBR. They say they are limited to purely a physical health role, which does not acknowledge or take advantage of their nursing knowledge, skills, and holistic treatment philosophy, and their knowledge of the residents gained through contact with them.
- All nursing staff complained about what they called devaluation by the administrative leadership of the facility. Some said they fear retribution from administration.

- All nursing staff said that their morale was very poor.
- Nurses reported that they are not encouraged and do not feel welcome to attend treatment planning meetings, but they are not forbidden to do so and may provide written input.
    - Record reviews showed no nursing staff present at any treatment planning meetings for the 16 residents reviewed in 2007. (Most Master Treatment Planning meetings in 2006 had nurses present.)
- Nursing staff indicated that their services were nearly completely separate from clinical, residential, and security functions. They reported that they have little contact with these functions, "nursing is very compartmentalized, we are not involved in overall treatment." Some reported conflicts with security.
- All nursing staff expressed dissatisfaction with the space in which they are required to administer medications (a "cook-chill" food service location). There are differences about the use of this space and compliance with Board of Pharmacy requirements among nursing staff, administrators, and different representatives of the pharmacy company serving the facility. Some nurses say they have reported these concerns to the Board of Nursing and Board of Pharmacy. Nursing staff also reported concerns to the DMHMRSAS Director of Clinical Pharmacy Services. Nurses say that a representative of the private pharmacy now providing services to the facility first declared that the location was inappropriate, then after (alleged) intervention from facility leadership, a different representative said the location was acceptable.
- Nurses reported that they must suspend operation if outside visitors come to see residents, as their office space is sometimes used for these meetings.
- Nurses reported conflicts with security officers and inconsistency among security supervisors. Some reported that security staff prevent provision of nursing care when security staff judge residents to be disruptive.
- Nurses reported concerns about the arrangement for contracting pharmacy services from a private company, rather than the DMHMRSAS pharmacy services.
- Nurses reported that they have had virtually no training on working with sex offenders other than the basic two week orientation that all staff receive.
- The medical records and program (clinical treatment) records are completely separate documents and are not integrated.
- The medical records were up to date and showed active treatment of health conditions.
    - All residents had complete and timely annual physicals.
    - Each physical evaluation was done by the same physician, whose tenure dates to the opening of the facility.

Administrative and Clinical Leadership Position

Comments from leadership staff included the following:

- Nursing's role is medical – physical health and comfort – not behavioral. They do not have a role in behavioral treatment.
- They may provide input to treatment if they wish.

- This is a different model than they (mental health program nurses in general and the VCBR nurses in particular) are accustomed to. They are used to a mental health model in which the nurse is a principal provider of treatment.
- Nursing staff need training and exposure to sexual offender treatment to be effective. Without this specific training their efforts are counter productive with these residents. When group treatment observation opportunities have been offered, nurses have said they do not have time.
- The private contractual pharmacy provider was selected from a state contract listing on the basis of cost and with an eye to the facility's growth and location in Nottaway County and the concern that Piedmont Geriatric Hospital could not meet the demand of the predicted population increase at VCBR.
- The new facility will feature more adequate space for medical services and current concerns should be completely addressed.

Finding A.5 Psychiatric services at VCBR may be inadequate to identify and treat psychiatric issues.

- Eight records (of the 16 total in the sample) were reviewed for psychiatric information.
    - Each physical examination in the records contained a section entitled "Psychiatric Examination." The consulting physician, not a psychiatrist, completed this section for each resident and stated "no abnormalities" for each, including (see below) the one resident of the eight who has a psychiatric diagnosis and is being prescribed psychiatric medications.
    - Of the 8 residents reviewed, only one had a formal psychiatric diagnosis and was receiving psychotropic medications. This resident was seen by a consulting psychiatrist and these medications were prescribed by the psychiatrist. Deferring treatment of psychiatric disorders to the consulting psychiatrist was described by VCBR clinical staff to be the general physician's strict preference and consistent practice.
- OIG staff reviewed diagnostic information for all 54 residents shown in DMHMRSAS data reports for September 4. Six residents (11%) had Axis I diagnoses of severe mental illnesses (schizophrenia, bipolar disorder, or major depression). 50% had substance abuse diagnoses. 20% had diagnoses of mild mental retardation or borderline intellectual functioning. 83% had personality disorder diagnoses. All had appropriate sexual offender diagnoses.
    - Consultation with state and national sex offender treatment experts confirmed that this diagnostic pattern is typical of such populations.
- According to the clinical leadership, full psychiatric evaluations are not done for the residents. Initial evaluations are provided by contractual staff, all psychologists who are supervised by the DMHMRSAS Office of Violent Sexual Predator Services. No psychiatric evaluations were found in the 8 charts reviewed by the OIG.
- OIG inspectors learned that the facility had employed a contract psychiatrist for one half day every other month, but that this person suddenly resigned recently.

- OIG inspectors were informed that the facility was looking for temporary, part time psychiatric staff through private agencies that provide *locum tenens* staffing, by telemedicine with VCU/MCV, and by attempting to contact psychiatric staff at Piedmont Geriatric Hospital (PGH) to see if anyone there might be interested in part time work when VCBR moves to Nottaway County, next to PGH. (As of the November 7 visit, leadership said that a contractual arrangement had been secured on a P14 basis with an individual PGH psychiatrist.)
- Program staff expressed the opinion that more residents need to be assessed for psychiatric conditions and needs.
- Facility leadership described the role of psychiatry as "consultative" and said that capacity was adequate now, but would need to be increased as the population grows.

B. Security Findings

Finding B.1 Facility security arrangements function well and provide for adequate control.

- There have been no escapes or any attempted escapes since the facility opened in 2004.
- At each of the OIG visits, inspectors observed significant perimeter security and rigorous control of entry and exit of all VCBR staff (including routine searches of members of the facility leadership), visitors, maintenance, and service personnel.
- Security leadership reported that, while turnover in the first years of operation was higher than desirable for continuity, turnover from FY06 to the present is much reduced.
- The facility administrative leadership has DOC experience and is supportive and knowledgeable about security matters.
- Security leadership who were interviewed reported reasonable comfort with the security arrangements, considering them to be appropriately secure, while noting some limitations necessitated by the nature of the program and the legal status of the residents (e.g., officers are not armed, some resident infractions must be dealt with by court action, rather than directly by the facility, as is the case in DOC facilities.)

C. Workforce Findings

Finding C.1: Staff vacancies and constant turnover significantly decrease the effectiveness of active treatment programming at VCBR. Recruitment and retention of clinical staff is an ongoing problem at the facility.

- Nearly every resident and all staff members commented on the high vacancy rate of clinical staff and its effect on provision of treatment.
- Supervisors acknowledge problems of retention, noting that they often have to lead treatment groups themselves due to shortages of clinical staffing. Filling in for vacant staff detracts clinical leadership from providing staff training, program development, and other supervisory duties.

- Of the 5 direct service clinical staff (excluding supervisory staff) who had been employed at the time of the last OIG visit in May 2006, only 1 remained employed as of November 7, 2007.
- Of the 7 direct service clinical staff (excluding supervisory staff) employed at the time of the September 2007 visit, only one had been employed in that position for more than 3 months. By November 7, 2 of these 7 staff had resigned.
- Staff was asked to what degree is turnover of program staff a problem at VCBR.
    - All said it is a major problem, causing a lack of connection with clients and increased workload for available staff. Some noted that turnover weakens program consistency and continuity and that residents use these factors to become disruptive.
    - When asked what causes turnover at VCBR, staff cited workload, alleged favoritism by supervisors, differences with treatment philosophy, and an atmosphere of suspicion and "write–ups for minor offenses."
    - Most staff (clinical, medical, and security) rated morale as low.
- Members of the executive team acknowledged high turnover rates.
    - They noted the reality of working with this population is "daunting."
    - Leaders noted disconnect with aspirations of young, entry level treatment professionals and the low expectations for success for this population: "We have an identity issue. Residents and some staff see it as no more than a prison, but with an indeterminate sanction." "No clear goal, no release date." "Other tough, difficult populations are seen as patients – these guys are seen as criminals who choose to offend."
    - Leaders acknowledge the circular effects of high turnover: increased workload, rapid burnout, "always playing catch up."
    - A feeling of being over-scrutinized (by judges, attorneys, residents, families, General Assembly, DMHMRSAS, OIG, etc.) was also mentioned.
    - Leaders expressed optimism that they now have a good core staff and that they have "turned the corner." They hope that the new facility will help increase retention, noting the many difficulties with the current facility. They noted that two highly qualified clinicians, experienced in work with sexual offenders, and an art therapist have just been hired.
- The Director of Human Resources for DMHMRSAS reported the following turnover statistics for VCBR (all staff positions):
        - FY05 49.8%
        - FY06 44.8%
        - FY07 51.5%
    - These figures are significantly higher than the next highest facility, (CCCA, 35.5% in FY07) and double or triple that of all of the other facilities.
    - The DMHMRSAS Director of Human Resources expressed significant concern about turnover and vacancies at VCBR.

Finding C.2: Direct service clinical staff, as well as medical and security staff receives very little training on treatment of sex offenders.

- Most of the staff interviewed said there had been no or very little training on sex offender treatment since they had come to VCBR.
- At the time of the OIG visits, only one direct service program staff member had formal academic preparation in sex offender treatment before coming to VCBR. (OIG staff were later informed that two persons with significant SVP program experience in other states were hired after the OIG visits.)
- Clinical staff reported that their on-site training has been limited to the same two-week, multi-subject orientation that all staff (security, administrative, etc.) undergo at the start of their employment. Some stated that the time devoted to sexual offender diagnoses and treatment was no more that 2 hours.
- Most clinical staff reported that they do receive knowledgeable and supportive supervision and that this is the source of most of their training. Most reported being given a program manual on treatment of sex offenders.
- The executive team reported that staff "have been exposed to a lot of training," noting that security and clinical staff went to New Jersey for a clinical conference and security staff participated in training at the Department of Corrections. They reported that the facility is planning to make use of the online training programs of the College of Direct Support and hopes to develop joint training activities with Piedmont Geriatric Hospital when the facility moves next to the PGH location.
- OIG staff reviewed training logs submitted by facility leadership for all employees for FY2007.
    - 159 employees from all job categories are documented as having received one or more training sessions in the year.
    - Of 159 persons, only one received any training on topics specifically identified as relating to working with sexual offenders (apart from the standard orientation training that is received by all new employees).
    - Of the many dozens of listed training topics, sessions, workshops, and conferences, only four topics were specific to sexual offenders, and all of these were received by this one person.
    - Only one other session or training listed was specifically clinical in nature, an 8 hour workshop on trauma informed care. (This training was received by a clinician – a different person than the one mentioned above.)
    - All together only two of 159 staff were documented as receiving any clinical training during the year.
- The curriculum for the orientation training session provided for all employees was reviewed by OIG staff.
    - Orientation training duration as recorded in the training log ranged from 30 hours to 88 hours, with 8 different levels (number of hours received) recorded among employees.
    - The orientation curriculum document provided to the OIG covers 80 hours, including such topics as benefits and payroll information, human rights, HIPAA, safety, infection control, security, first aide, TOVA, policies, etc.

- Of these 80 hours, 12 hours may be considered programmatic or clinical. Unless all of these topics are specifically adapted to describe the sexual offender population, it is not known how much of this clinical training is specific to sexual offenders. Only the topics identified by an asterisk (*) are provided by the sexual offender clinical leadership staff (Dennis and Pechura). The other topics are presented by security/training staff:

    - DMHMRSAS strategic plan
    - Code of Virginia/SVP Program*
    - Mental health*
    - Suicide prevention*
    - Residents and manipulation
    - Conflict management/resolution
    - Alcohol and drug program
    - College of direct support
    - Treatment planning*
    - Psychosocial rehabilitation*

Section II – Recommendations

Recommendation 1: It is recommended that the DMHMRSAS establish a permanent VCBR Advisory/Oversight Committee by no later than April 1, 2008. The responsibility of this committee will be to provide appropriately specialized and knowledgeable oversight and review of VCBR programs and operations for the purpose of assuring maximum effectiveness of the facility and to make recommendations for improving effectiveness to the VCBR director and the DMHMRSAS Commissioner. It is further recommended that consideration be given to including representatives from the following areas on the advisory/oversight committee: experts in the treatment of violent sexual offenders from model programs across the nation, staff of the DMHMRSAS OSVPS, other appropriate staff from DMHMRSAS central office, the judiciary, and the community. (Response to Finding A.3)

> ***DMHMRSAS Response*** *– The DMHMRSAS Office of SVP Services is implementing this recommendation. The first meeting of the Advisory Board is scheduled for February 7 and 8, 2008.*

Recommendation 2: It is recommended that the newly established VCBR Advisory/Oversight Committee carry out the following tasks as a part of its initial work plan:

- Identify and review the factors that have contributed to low levels of treatment, recreational, and educational activities at VCBR and develop recommendations, including changes in facility culture, policy, procedures and program that will significantly improve and increase the levels of activity in these services at VCBR. (Response to Finding A.1)

- Review the role and support for medical, nursing, and pharmacy services at VCBR and recommend any needed changes. (Response to Finding A.4).
- Assess the role and adequacy of psychiatric resources at VCBR and make recommendations for any changes that are needed. (Response to Finding A.5
- Study the facility's staff retention and recruitment situation, in coordination with the DMHMRSAS Office of Human Resources, assessing such areas as leadership, organizational culture, support of staff, training, pay and benefits, etc., and recommend specific actions to improve staff continuity. (Response to Finding C.1)

DMHMRSAS Response: *This OIG recommendation identifies three areas that need to be addressed in the Plan of Correction:*

- *Factors that contribute to low levels of service delivery;*
- *The impact of current policy and procedures;*
- *The impact of culture; and*
- *The impact of program design.*

In response to the OIG's report and recommendations, the OSVP is working to empanel an VCBR Advisory and Oversight Committee. The role of this Committee will be to work with the VCBR to guide the revision of policies, procedures, and practices relating to staff management and the delivery of services to program residents.

By July 1, 2008, with the guidance and oversight of the VCBR Advisory/Oversight Committee (VCBR O/C), the management staff of the VCBR (VCBR), consulting with the DMHMRSAS Office of SVP Services, and the Office of Facility Operations will accomplish the following tasks, measured by the identified outcomes.

a) <u>Factors impacting service delivery</u>. The VCBR will identify and list the factors that facilitate or interfere with the delivery of weekly treatment, recreation, and educational hours provided to each resident.
Outcome: List and description of facilitating/interfering factors, delivered to the VCBR O/C.
Target completion date: 1 March 2008.

b) Working from this list (from a), the VCBR will articulate and implement specific strategies to strengthen those factors that enhance service delivery and weaken the influence of those that interfere with service delivery.
Outcomes: Articulated strategies for each factor identified in "a" delivered to the VCBR O/C.
Target completion date: 15 March 2008.

c) Evaluate the efficacy of these strategies (from b) on increasing service delivery to residents at the VCBR.
Outcome: Documentation on increases or decreases in treatment, recreation, and

educational - hours per week greater or less than those reported in the OIG report - in services delivered to residents of the VCBR, delivered to the VCBR O/C.
Target completion date: 1 July 2008.

d) Policies and procedures impacting service delivery. Identify and list the specific VCBR policies and procedures that act as barriers to the delivery of treatment, recreation, and educational services to residents of the VCBR.
Outcome: Report listing and describing barrier policies and procedures delivered to the VCBR O/C.
Target completion date: 1 March 2008.

e) Working from this list (from d), articulate and implement specific policy changes to reduce barriers to service delivery to residents at the VCBR.
Outcomes: Documentation of implementation of these strategies for each factor identified in "d", delivered to the VCBR O/C.
Target completion date: 1 April 2008.

f) Evaluate the efficacy of these strategies (from e) on increasing service delivery to residents at the VCBR.
Outcome: Documentation on increases or decreases in treatment, recreation, and educational - hours per week greater or less than those reported in the OIG report - in services delivered to residents of the VCBR, delivered to the VCBR O/C.
Target completion date: 1 July 2008.

g) Culture. The VCBR will invite the LEEP team from DMHMRSAS Central Office to conduct an anonymous survey of all staff to identify and articulate the cultural impediments to retention.
Outcome: A completed LEEP survey response matrix delivered to the VCBR and the VCBR O/C.
Target completion date: 1 April 2008.

h) Working from this matrix (from g), the VCBR, working with Central Office Human Resources, will identify policies, procedures, and other factors formal or informal, that negatively impact agency culture and staff retention.
Outcome: List and describe the impact of these identified policies, procedures, and factors and deliver this document to the VCBR O/C.
Target completion date: 15 April 2008.

i) Evaluate the effectiveness of these culture changes.
Outcome: Documentation of improved retention of all staff, delivered to the VCBR O/C.
Target completion date: 1 July 2008.

j) Program operations. Working with the VCBR O/C, Central Office of Human Resources, and the OSVP, the VCBR will review the current VCBR HR policies and actual practices as it relates to the structure and operation of treatment provision between security, clinical, medical, pharmacy, psychiatry, and nursing and identify those practices that interfere with the full implementation of the treatment team approach as articulated in Departmental Instruction 111.
Outcome: A plan to integrate all service delivery units identified above, delivered to the VCBR O/C.
Target completion date: 1 April 2008.

k) Full implementation of "j".
Outcome: Documentation of full implementation of "j", delivered to the VCBR O/C.
Target completion date: 15 April 2008.

l) Evaluation report on the efficacy of this approach, delivered to the VCBR O/C.
Target completion date: 1 July 2008.

m) Working with the OSVP, develop a VCBR-specific active treatment appendix, consistent with Departmental Instruction 111.
Outcome: Completion of a VCBR-specific active treatment appendix, to the VCBR O/C.
Target completion date: 1 May 2008.

n) Working with the OSVP, rationalize the VCBR treatment team approach to DI 111 (TX) 01.
Outcome: Completed VCBR-specific Appendix to DI 111 (TX) 01, delivered to the OSVP.
Target completion date: 1 May 2008.

o) Treatment model. Working with the VCBR O/C, the VCBR will review and revise the SVP treatment program.
Outcome: Acquisition of program manuals from all SVP programs, delivered to the VCBR O/C.
Target completion date: 1 May 2008.

p) Working with the VCBR O/C, VCBR will develop a program treatment manual to include full articulation of:
- *the overarching goals of treatment,*
- *the program's vision and mission statements,*
- *problem statement,*
- *philosophy,*
- *underlying theoretical assumptions,*
- *treatment assumptions,*
- *how service units (security, clinical, medical, nursing, pharmacy, psychiatry, and administration) will integrate,*

- *the components of active treatment, and*
- *any other elements found to be key and critical to the delivery of a clinically informed, evidence-based practice model.*

Outcome: Draft treatment manual.
Target completion date: 1 July 2008.

o) Fully implement the program treatment manual.
Outcome: Documentation and demonstration to the VCBR O/C, of full implementation of the program treatment manual.
Target completion date: 1 September 2008.

Recommendation 3: It is recommended that the facility, in concert with the leadership of DMHMRSAS, develop a mission and goals statement that accurately reflects the intended purpose of VCBR and ensure that facility policies, active leadership, program design, staff training, and individual residents' goals and treatment activities reflect the facility's revised mission and goals on an ongoing, operational basis. (Response to Finding A.2)

DMHMRSAS Response - By *July 1, 2008, the management staff of the VCBR, consulting with the DMHMRSAS Offices of SVP Services, Human Resources, Facility Operations, and Quality Management, will develop new value, mission, and goal statements reflective of Department's values of Recovery, Patient Centered Planning, and Dignity and Respect for staff and residents. These core statements will be shared with all staff and residents through public meetings, training, and through modeling by leadership at all levels.*

Following this, the management staff of VCBR, consulting with the DMHMRSAS Offices of SVP Services, Facility Operations, and Quality Management, will review and amend the facility's policies and procedures, the treatment program design, and staff training curriculum and content, and the individual resident goals and treatment activities, to ensure they reflect the values, mission, and goals of the VCBR.

Recommendation 4: It is recommended that the DMHMRSAS, in coordination with VCBR, review existing national accreditation systems to determine the appropriateness and validity of these systems for sex offender treatment programs. If it is determined that an existing accreditation system will be of value, it is recommended that DMHMRSAS pursue accreditation for VCBR. (Response to Finding A.3.2)

DMHMRSAS Response: *At present, there are no national or international accreditation systems for SVP programs. Please see "j" above for details on developing a clinically informed, evidence-based practice model program that is consistent with the state-of-the-known for providing SVP treatment in this country.*
Outcome: Draft set of treatment standards, consistent with treatment manual (from "o" in response to Recommendation 2).

Target completion date: 1 January 2009.

Recommendation 5: It is recommended that the facility, with the involvement of DMHMRSAS staff, including the Office of Sexually Violent Predator Services, revise and expand the provision of training in topics specific to working with persons who are sexual offenders, and that such training occur regularly for all employees, including treatment, medical, and security staff. (Response to Finding C.2)

> ***DMHMRSAS response*** *- By July 1, 2008, the management staff of VCBR, consulting with the DMHMRSAS Offices of SVP Services, Facility Operations, and Quality Management, will develop and implement a training curriculum for all staff on the characteristics of, and the provision of treatment services to, persons who are violent sexual offenders.*

Section III – Status of Previous Active Findings

A. OIG Report #119 (June 27, 2005)

Finding #1: Facility administration expresses serious concern that security officers may not be able to protect the public while accompanying residents outside the facility because behavioral management techniques available to the officers in TOVA may not be adequate in certain situations.

Recommendation #1: It is recommended that DMHMRSAS conduct a study to fully understand the issue of security officer authority to manage resident behavior while outside the secure facility and develop solutions that will resolve any identified concerns.

> ***DMHMRSAS Response (2006):*** *The Department Facility Operations staff in cooperation with VCBR administration and security personnel will meet in August 2005 to assess the needs of the security personnel related to potential aggression from the residents while off the campus. In addition, a review of the level and type of response appropriate to these situations will be undertaken. It is important to the Department to maintain both security and the therapeutic environment needed for the civilly committed residents of VCBR.*

> ***DMHMRSAS Response (November 2007)*****:** *After consulting with the Assistant Commissioner for Facility Operations, the Director of the Sexual Predator program, the Office of the Attorney General, and security staff, the previously identified concerns have been resolved. We believe that the techniques prescribed in Therapeutic Options of Virginia should adequately address any potential security threats to public safety. Two security staff members are assigned to provide escorts for residents when outside the facility at all times. In addition, the facility has developed detailed security instructions to address potential security threats, including escape attempts. These instructions include the immediate notification and request for assistance to state and local law enforcement agencies. There have been no escape attempts to date.*

Status of Recommendation – Determined inactive.

B. OIG Report #130-06 (May 16, 2006)

Finding 1.3: The majority of residents identified boredom as a problem, particularly during non-programming times.

Recommendation 1.3: It is recommended that VCBR leadership in conjunction with the residents and staff develop strategies for providing increased activities during non-programming times. It is also recommended that the clinical staff review the effectiveness of suspending programming for an extended period during each review cycle.

DMHMRSAS Response (2006): *VCBR now provides modified treatment programming each quarter, replacing the two-week gap in programming. During this time, residents continue to receive programming and have the ability to meet with their case manager, therapist, and treatment team to access their progress with their treatment goals.*

VCBR has actively recruited for a recreation therapist for four months. Interviews were recently conducted and no viable candidate was found. Recruitment continues.

Residents have the opportunity to access the following activities: board games, cards, movie rentals, video games, basketball, volleyball, horse shoes, walking track, etc. VCBR has installed exercise equipment on the recreation yard, contracted with Netflix to provide video rental service, and purchased additional video games, movies, and board games.

Presently, the current facility infrastructure has no internal recreation space. Thus, recreation is limited to the resident living areas and outside activities. The new facility will provide space for a gymnasium, exercise, art, music therapy, educational and vocational activities.

OIG Assessment of Progress: (June 2007)

Executive Team leadership reported to the OIG on June 27 that the facility has determined that it really cannot eliminate the two week break in programming. The time is needed for staff to regroup, prepare for a new treatment cycle, and prepare and give feedback to residents on progress to date. The facility is still attempting to hire and retain an activities coordinator. Space limitations are still a significant barrier. It is anticipated that the new facility will afford more appropriate space for recreational activities.

These explanations stand in direct contradiction of the plans the facility leadership identified as *having already been implemented* in their May, 2006 response to the OIG finding and recommendation (see above).

The discrepancy was addressed with facility leadership on November 7. Leadership responded that they found the clinical staff needed a break period to complete progress notes, consult with each other and plan treatment, provide feedback to the resident, and prepare for the next series of groups. It was hoped that the break period could be filled with recreational and educational activities, but the facility has been unable to hire and retain teachers, recreational therapists, and art therapists. Having recently hired an art teacher, the leadership is hopeful that the recreational/activities gap can begin to be filled.

Status of recommendation: Remains Active

OIG Report #130-06 (May 16, 2006)

Finding 2.2: Security and clinical staff have different perceptions regarding the changes in programming and unit rules.

Recommendation 2.2: It is recommended that current channels of communication be reviewed in order to enhance information flow between clinical and security personnel. One goal of this would be to increase opportunities for incorporating ideas and comments by security staff in unit functioning and programming.

DMHMRSAS Response: *VCBR has placed an emphasis on increasing communication during security shift briefings to include providing training, reviewing policies and procedures, and sharing general information. Computers have been placed in staff break areas and designated locations on each ward so that clinical and security staff have greater access to policies, procedures, and shared information.*

Recently, VCBR identified and assigned direct care staff on each resident living unit to replace security officers during day and evening shifts. Our direct care staff interacts with and provides direction to the residents during programming hours. The supervision of residents by security staff has been reduced. This has brought greater consistency in the understanding and enforcement of ward rules and expectations.

To bring greater consistency, generic ward rules were established, posted on each living unit, and communicated to residents and staff. VCBR will submit a comprehensive package to the State Human Rights Committee for their review in December that includes ward rules, expectations, and privileges that are specific to the resident's progress with treatment objectives.

All security staff members were recently given the opportunity to participate in the development of post orders that clearly define security role and job expectations.

Security staff members at all levels are regularly invited to participate in resident treatment planning. By documenting positive and negative behaviors, all staff members have the opportunity to have a direct impact on treatment planning for all residents.

Work hours for key leadership positions have been adjusted to bring consistency throughout the facility by providing more supervision and leadership across all shifts

OIG Assessment of Progress: (November, 2007)

OIG staff addressed this issue in interviews with the executive leadership team, supervisors, and staff at all three site visits.

- The executive team leadership responded that efforts have been made to improve communication across the different groups of staff. Leadership said that line staff are more involved in decision making. They said they are "pushing responsibility for communication down the hierarchy" and "constantly looking for ways to link people."
- Of 20 staff interviewed, 16 said communication across the types of personnel (security, residential, clinical, nursing, administration) is still a problem. Here is a representative listing of their comments:
    - serious problem, still a problem
    - security/residential not on the same page, have conflict
    - security and residential have separate morning briefings, poor communication
    - it is a complex issue of values, not just communication. It is discussed in orientation, but reality hits later. We have tried cross training, meetings, but VCBR is still trying to figure out roles.
    - All five nurses made variations of the following comment: "We're totally separate from all those groups."
- Four staff made positive comments (two program, two security):
    - better now, working as a team, mutual support
    - the housing coordinator role helps bridge gaps
    - we have little contact with security, but they help if residents are threatening.
- As noted in Finding A.1, while program staff was quite knowledgeable about specific residents' goals and treatment plans, none of the security or nursing staff who were interviewed were able to provide any specific information about individual residents' treatment.

Status of recommendation: Remains active